Macula and Diabetic Eye Center
New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

Date of Birth _____ Age _____ ☐ M / ☐ F Social Security #_____

Address _____
(Local) Street City State Zip

Full time Resident? Yes____ No____ If Part time, Dates spent here:_____

Address _____
(Out of State) Street City State Zip

Phone: Home (____) _____ Cell: (____) _____

Occupation _____ Employer _____

Work Address _____ Phone (____) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse/Guardian _____ Employer _____

Address _____ Phone (____) _____

Referred by: ☐ Friend/Relative _____ ☐ Doctor _____
Name Name

☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other _____

INSURANCE INFORMATION

☐ Medicare #_____ ☐ Medicaid # _____

☐ Workers Compensation (job injury) to whom is bill to be sent? _____

☐ Other Medical Insurance _____

Group # _____ ID #_____

Name/Address 2nd Insurance _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____ Relationship _____ DOB _____

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship _____

Address _____
Street City State Zip

Home Phone: (____) _____ Work Phone: (____) _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance *at time service is rendered*.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____